Women's Embarrassment over Answering Sexual Health Questions

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Abstract

The aim of this study was to assess young women's embarrassment when asked questions about their sexual health. Limited data has revealed that women have an openness to this topic. With an increasing number of sexually transmitted infections [STIs], young women are facing a growing likelihood of acquiring one. Research about young women's sexual health is a topic that needs to be further researched. In this study, young women were asked to rate their level of embarrassment in regard to certain sexual health questions. Additionally, the participants supplied data on the number of vaginal, oral and anal sex partners they have had, and at what age their first vaginal, oral and anal sexual encounters took place. The results of this study produced information that showed the level of embarrassment was not significantly different between caucasian women and women of color, or women with religious affiliation and women without any religious affiliation. By gaining this knowledge, healthcare professionals will be better able to begin dialogue on the topic of sexual health. Understanding young women's level of embarrassment on this topic, healthcare professionals can better educate young women on the risks associated with STIs and risky sexual behavior.

Keywords: women, embarrassment, sexual health questions

Sexually Transmitted Infections (STIs) are at pandemic proportions and women are disproportionately affected by these infections (Centers for Disease Control (CDC), 2013). One potential barrier to assessing women is embarrassment on both the part of the woman seeking assistance and the practitioner offering assistance in sexual health. These perceptions of embarrassment are well documented; however, it is primarily from the practitioners' viewpoint (Wendt, Lidell, Westerstahl, Marklund & Hildingh, 2011; Gott, Galena, Hinchliff & Elford, 2004; Wendt, Hildingh, Lidell, Westerstahl, Baigi & Marklund, 2007). The purpose of this research study is to examine these perceptions of embarrassment from the woman's perspective.

Literature Review

Women and STIs

STIs such as chlamydia, herpes, hepatitis, and genital warts are continuing to be a threat to society (CDC, 2013). There is an estimated 110 million cases of STIs in the United States, and 20 million new cases each year, 51% of those cases are thought to be affecting women (CDC, 2013). Women are also disproportionately affected by STIs. There are several reasons for this. To illustrate, the most frequently reported STI in women, chlamydia, often goes undetected due to a lack of symptoms and consequently, lack of testing (CDC, 2012). A delay or lack of diagnosis can cause permanent damage to a female's reproductive organs, resulting in infertility, severe chronic pain, or complications during pregnancy (CDC, 2012). Some STIs can be diagnosed and treated, but because of the possibility of prior transmission and absence of symptoms, a subject's past oral, anal and vaginal sex partners from the previous two months need to be notified and tested to assess for possible treatment needs (CDC, 2012).

Transmission of STIs can occur when there does not appear to be any physical evidence of an infection (CDC, 2012). Participation in risky sexual behaviors, such as having multiple sex

partners and not using condoms appropriately, can increase a woman's chance of getting an STI (CDC, 2012). Research has found adolescent women underestimate their susceptibility to STIs. (Ethier, Kershaw, Niccolai, Lewis & Ickovics, 2003) As reported by the CDC, "young women face the most serious long-term health consequences" (CDC, 2013). If STDs are symptomless or are ignored, ectopic pregnancy, chronic pelvic pain, and infertility can result (CDC, 2013). Consequences such as these can remain unknown and undetected until a woman discovers she is unable to conceive when trying later in life (CDC, 2013). Each year approximately 24,000 women are newly affected by infertility caused by undiagnosed STDs (CDC, 2013). Women are affected sexually, psychologically, and socially by infertility and involuntary childlessness (Wendt et al., 2007).

Because of the prevalence of STIs in women and the under diagnosis and treatment of these infections, communication with health care practitioners is paramount. Yet, despite the openness of culture in regards to sexuality, sexual lives may be too personal to discuss (Verhoeven, 2003).

Embarrassment in Discussing Sexual Health Issues

Nearly 100% of women seeking gynecologic care have at least one sexual health concern (Nusbaum, et al., 2000). Although some studies indicate that women are comfortable sharing sexual health information (Wendt et al., 2011), many studies indicate that this is not the case (Nurutdinova, et al., 2011; Nusbaum, et al., 2004). Only half of women have their sexual health concerns addressed with a practitioner (Nusbaum, et al., 2004). Reasons why sexual health issues are not addressed are plentiful. These reasons include: embarrassment and discomfort with the topic on the part of the woman seeking care and the practitioner (Nusbaum, et al. 2004; Gott, Hinchliff & Galena, 2004), attitudes of healthcare professionals [HCPs] (Hambly, 2006),

preconceived ideas or stereotypes about sexuality within different subgroups of women (e.g., older, lesbian, etc.; Nusbaum, et al., 2004; Bjorkman & Malterud, 2007) and a lack of training in communication about sexuality (Gott, et al., 2004). The majority of HCPs do not feel comfortable with asking women about their sexual experiences (Nurutdinova, et al., 2011; Weerakoon, et al., 2004). The majority of practitioners surveyed acknowledge that more training is needed in regards to sexual health communication (Gott, et al., 2004; Markham, et al., 2005). However, even when HCPs are trained in communication techniques there are only modest increases in practice in introducing sexual health topics (Macdowall, et al., 2010).

In sum, given that there is significant discomfort and embarrassment in discussing sexual health questions, the purpose of this research study was to examine women's level of embarrassment with answering sexual health questions on a questionnaire. The following research questions guided this study:

1. What was their level of embarrassment at being asked questions regarding sexual behaviors?
2. How helpful are sexual health questions?
3. Is there a relationship between level of embarrassment and number of sexual partners?
4. Is there a difference in level of embarrassment between Caucasian women and women of other ethnicities?
5. Is there a difference in level of embarrassment between women who identify with a religious faith and those who do not?

Methods

This study was a secondary analysis of data. The original study examined the psychometric properties of a new instrument designed to assess women's sexual risk taking.

Sample

A convenience sample of 349 young women (ages 18 – 35 years) was recruited for the parent study. For the research questions answered here, 149 women were asked to respond. The average age of the study participants was 20.51 years old (*SD* = 2.36). Eighty-two percent of the sample was Caucasian, the rest of the sample was African American (Appendix A). Religious affiliation data were also collected. Due to limited study participants in some categories, the sample was focused into religious affiliation (N=103) and no religious affiliation (N=45).

Procedure

Women were recruited for the parent study through advertisements placed in a University on-line news email. Interested women contacted the principal investigator (PI) of the parent study. Upon that contact the purposes of the study were explained via email. If women were still interested, they contacted the PI again and were given a link to a secure, on-line website where the informed consent and study questionnaires were located. Participants were paid $10 upon completion of the study by sending their address to the PI in a separate email unaffiliated with the study.

Instruments

Only instruments connected with this secondary analysis are discussed here. The first instrument was a demographic questionnaire assessing age, ethnicity, religious affiliation, and other basic demographic characteristics of the sample. For this analysis two questions regarding the questionnaire were analyzed: 1) please rate your level of embarrassment with this

questionnaire (0 – not embarrassed at all to 5 – extremely embarrassed); and 2) How helpful are these questions in raising your awareness of sexual risk behaviors (0 – not at all helpful to 5 = extremely helpful).

Data Analysis

Data were analyzed by research question. Descriptive statistics, Pearson correlations, and *t*-tests were used to analyze the questions.

Results

Results of this study are presented by research question. This study involved women of varied ethnic origin, sexual orientation and religious affiliation (data located in Appendix A).

Research Question #1 Women rated their level of embarrassment of being asked questions regarding sexual behaviors 1.62 (*SD*=.97). Hence, there was a low level of embarrassment in answering sexual health questions on a questionnaire.

Research Question #2 Women rated how helpful sexual health questions are as 2.97 (*SD*=1.13). Women rated these questions as moderate in being helpful in raising awareness about sexual health.

Research Question #3 assessed the relationships between embarrassment and sexual demographics (Appendix B). Only two correlations were significant. Increased age of vaginal sexual debut was associated with more embarrassment (r =.32; p =.00) and increased age of anal sexual debut was associated with increased embarrassment (r =.36; p =.01).

Research Question #4 addressed differences in embarrassment by race. There were no significant differences in the level of embarrassment of women of color and caucasian women. Women of color rated their level of embarrassment with questions to be 2.04 (*SD* =1.34), while caucasian women rated their embarrassment as a 1.53 (*SD*= .85) (Appendix C).

Research Question #5 concerned level of embarrassment and religious affiliation. There were no significant differences in the level of embarrassment of women with a religious affiliation as compared to no religious affiliation. The average level of embarrassment calculated was 1.64 (*SD*=.99) and 1.62 (*SD*=.96) respectively (Appendix D).

Discussion

This study is the first to address level of embarrassment in answering sexual health questionnaires. Overall, women felt little embarrassment in answering sexual health questionnaires in this format. This study also found there were no significant differences in the embarrassment of women of different races, or religious beliefs; although significant relationships existed for an older age of sexual debut and higher level of embarrassment. This is in contrast to other studies (Gott et al., 2004; Verhoeven et al., 2003), which found women were embarrassed to discuss this with practitioners.

The study results must be viewed in light of its limitations. The sample was a convenience sample of young women. The views here may not be indicative of all women. Caucasian women were over-represented in this sample, even though there were no significant differences between caucasian and women of color. All women knew they were answering questions about sexual health; hence, women who were not embarrassed to begin with may have self-selected into the study.

Conclusion

In general, women were not embarrassed to answer sexual health questions on-line without a practitioner present. Practitioners may want to adapt sexual health questions to be in an on-line or paper format for ease of both practitioner and patient.

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Appendix A
Demographic Percentages of Women Involved in Study

	n (%)
Race	
Caucasian/White/European American	122 (82.43)
Multi-Racial or Mixed	9 (6.08)
African American/Black	8 (5.41)
Asian American/Asian	4 (2.70)
Hispanic/Latino	3 (2.03)
Other Ethnicity	2 (1.35)
Sexual Orientation	
Heterosexual	142 (95.95)
Bisexual	4 (2.70)
Lesbian	1 (.68)
[no category]	1 (.68
Religious Affiliation	
Christian	85 (57.43)
None	45 (30.41)
Other	11 (7.43)
Buddhist	3 (2.03)
Jewish	3 (2.03)
Muslim	1 (.68)

Appendix B
Intercorrelations for Women's Level of Embarrassment and Sexual History

Measure	1	2	3	4	5	6	7	8
1. Level of embarrassment with questions	--							
2. How helpful are questions	.16	--						
3. What age was first vaginal sexual intercourse	.32**	-.07	--					
4. How many people vaginal sexual intercourse	-.02	-.09	.19*	--				
5. At what age first oral sexual intercourse	.12	.01	-.03	.55**	--			
6. With how many people oral sexual intercourse	-.05	-.05	.10	-.16	.72**	--		
7. At what age first anal sexual intercourse	.36*	.00	.28	.49**	-.11	.49**	--	
8. With how many anal sexual intercourse	.06	.16	.01	.00	.41*	-.11	.32*	--

Appendix C

Embarrassment Differences between Women of Color and Caucasian Women

	Women of Color		Caucasian Women				
	M	SD	M	SD	df	t	p
Level of embarrassment with questions	2.04	1.34	1.53	.85	29.47	1.84	.08
How helpful are questions	3.19	1.20	2.92	1.12	146.00	1.12	.26

Appendix D
Embarrassment Differences between Women with Religious Affiliation and Without Religious Affiliation

	Religious Affiliation		No Religious Affiliation				
	M	SD	M	SD	df	t	p
Level of embarrassment with questions	1.64	.99	1.62	.96	143.00	.10	.92
How helpful are questions	2.93	1.13	3.07	1.14	143.00	-.67	.50